BUFFALO LABORERS' WELFARE FUND
OUTSIDE HEALTH INSURANCE AFFIDAVIT
(MUST BE GROUP SPONSORED)

Participant's Name: _____ SS#: _____

I have _____ through _____
(Name of Insurance Company) (Employer, Spouse's employer, or other)

ID#: _____ Group #: _____

Spouse's Name: _____ SS#: _____

My spouse has _____ through _____
(Name of Insurance Company) (Employer, Spouse's employer, or other)

ID#: _____ Group #: _____

Dependents:

Name: _____ SS#: _____ Date of Birth: _____
Name: _____ SS#: _____ Date of Birth: _____
Name: _____ SS#: _____ Date of Birth: _____
Name: _____ SS#: _____ Date of Birth: _____
Name: _____ SS#: _____ Date of Birth: _____
Name: _____ SS#: _____ Date of Birth: _____

My dependents have _____ through _____
Name of Insurance Company (Employer, spouse's employer or other)

ID#: _____ Group #: _____

OTHER INSURANCE COVERAGE:

Name of Other insurance **(If none, state "none")**

Optical _____
Dental _____

PLEASE ENCLOSE COPIES OF YOUR CURRENT HEALTH INSURANCE CARDS.

I understand that if I lose my health insurance, I must immediately inform the Fund Office. Health insurance must be maintained at all times.

Participants Signature: _____ Date: _____

File: X:forms/welfare forms/outside coverage